



# Workers' Compensation Carrier Request

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240 • Fax: (916) 795-1280

## Section 1

You must complete the front side of this form, sign, date and forward to your workers' compensation insurance carrier.

## Member Information

If you have filed a workers' compensation claim for the illness or injury directly related to the application for disability or industrial disability retirement, this *Workers' Compensation Carrier Request* form (reverse side) must be completed by your employer's workers' compensation insurance carrier.

Name of Member (First Name, Middle Initial, Last Name)		Social Security Number
Employer Name		
Claim Number 1	Date (mm/dd/yyyy)	Body Part(s)
Claim Number 2	Date (mm/dd/yyyy)	Body Part(s)
Claim Number 3	Date (mm/dd/yyyy)	Body Part(s)
Claim Number 4	Date (mm/dd/yyyy)	Body Part(s)

## Section 2

Send this form directly to your workers' compensation insurance carrier. They will complete the reverse side of this form and send the requested information to CalPERS.

## Authorization to Release Information

I have submitted an application for disability or industrial disability retirement with the California Public Employees' Retirement System (CalPERS). You are hereby authorized to furnish CalPERS, or its representative, any and all information, including photocopies of records in your possession, which CalPERS requires solely to assist in determining my physical or mental condition, illness, or disability. The purpose of this authorization is to assist CalPERS in determining my right to retirement or reinstatement under the Retirement Law pursuant to Government Code Sections 20128; and no other purpose. This authorization shall be valid for four years from the date shown below. A photographic copy of this authorization shall be as valid as the original.

Signature of Member	Date (mm/dd/yyyy)
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**This form continues on the back.**

Put your name and Social Security number at the top of every page.

Applicant's Name

Social Security Number

### Section 3

Your help is needed in the evaluation of my eligibility for disability or industrial disability retirement.

Be sure to send CalPERS a copy of all medical reports for the claim number(s) listed.

Include job descriptions/ job analyses, depositions, investigation reports, videotapes, and approved orders from the Workers' Compensation Appeals Board.

### To Be Completed By Workers' Compensation Insurance Carrier

Claim Number 1

WCAB Number

Date of Injury(mm/dd/yyyy)

Body Part(s)

☐ No ☐ Yes

☐ No ☐ Yes

Liability Accepted

Condition P&S

Claim Number 2

WCAB Number

Date of Injury(mm/dd/yyyy)

Body Part(s)

☐ No ☐ Yes

☐ No ☐ Yes

Liability Accepted

Condition P&S

Claim Number 3

WCAB Number

Date of Injury(mm/dd/yyyy)

Body Part(s)

☐ No ☐ Yes

☐ No ☐ Yes

Liability Accepted

Condition P&S

Claim Number 4

WCAB Number

Date of Injury(mm/dd/yyyy)

Body Part(s)

☐ No ☐ Yes

☐ No ☐ Yes

Liability Accepted

Condition P&S

If liability is not accepted, provide reason (Reference Claim Number)

If condition is not permanent and stationary, what is estimated time period or date? (Reference Claim Number)

Has settlement occurred? ☐ Yes ☐ No

If Yes, ☐ Stipulated Award \_\_\_\_\_ %

Claim Number(s) \_\_\_\_\_

☐ C & R \$ \_\_\_\_\_

Claim Number(s) \_\_\_\_\_

☐ F & A \_\_\_\_\_ %

Claim Number(s) \_\_\_\_\_

Is there a possibility of third party liability? ☐ Yes ☐ No

Are you in the process of, or have you completed any investigations? ☐ Yes ☐ No If Yes, provide copies.

Are further exams scheduled? ☐ Yes ☐ No

Name of Doctor

Specialty

Appointment Date

☐ AME ☐ QME ☐ Treating Physician ☐ Other

Name of Doctor

Specialty

Appointment Date

☐ AME ☐ QME ☐ Treating Physician ☐ Other

Please use additional sheets to supply any additional background, information, or comments.

### Section 4

### Signature of Workers' Compensation Insurance Carrier

Signature of Workers' Compensation Representative

Date (mm/dd/yyyy)

Print Workers' Compensation Representative's Name

Phone Number

Mail to:

CalPERS Benefit Services Division • P.O. Box 2796, Sacramento, California 95812-2796